

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**

Division of Health Care Financing

HCF10109 (11/03)

**STATE OF WISCONSIN**

WI Stats. s .49.47(4) (c)

**MEDICAID REMAINING DEDUCTIBLE UPDATE****SECTION I – AGENCY INFORMATION**

1. Agency Name and Telephone Number	2. Agency Number	3. Worker ID
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**SECTION II – RECIPIENT INFORMATION**

4. Recipient's Name (Last, First, MI)	5. Medicaid ID Number
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6. Address (Street, City, State, Zip Code)
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**SECTION III – GENERAL INFORMATION**

7. Date of Service (mm/dd/yy)	8. Provider Number	9. Recipient's Share
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10. Amendment for Previous Form <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Previous Form Date (mm/dd/yy)
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12. Comments (attach a separate sheet if necessary)
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**SECTION IV – SIGNATURE**

13. <b>SIGNATURE</b> – Agency Designee	Date Signed
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Distribution:

White copy – Medicaid Fiscal Agent

Yellow copy – Provider

Pink copy – Agency Case File

## MEDICAID REMAINING DEDUCTIBLE UPDATE INSTRUCTIONS

This form is to be completed by the county economic support worker on the same day that the worker has completed processing the deductible in CARES. A large gap of time between the time the certification is completed and the time this form is keyed could mean the entire amount of the bill would be paid if the provider submitted the bill. Notification of eligibility must be sent from CARES to the Medicaid Fiscal Agent when the deductible is met.

This form should only be used if:

- a) The last bill, used to meet the deductible, can be considered for partial Medicaid payment of that bill, and
- b) The person who is being certified for Medicaid incurred the bill.

### SECTION I – AGENCY INFORMATION

- 1. **Agency Name and Telephone Number** - Enter the name and telephone number of your agency.
- 2. **Agency Number** - Enter your agency's three-digit code number.
- 3. **Worker ID** - Enter your six-digit worker ID number.

### SECTION II – RECIPIENT INFORMATION

- 4. **Recipient Name** - Enter the applicant's name (last, first, middle initial).
- 5. **Medicaid ID Number** - Enter the current Medicaid number for the applicant whose bill is being used to determine if s/he has met the deductible.
- 6. **Address** - Enter the applicant's street address, city, state, and zip code.

### SECTION III – GENERAL INFORMATION

- 7. **Date of Service** - Enter the dates of service which is also the date the deductible was met. This is the same as the dates of service on the bill used to meet the deductible.
- 8. **Provider Number** - Enter the provider number of the provider whose bill is being used by the applicant to determine if s/he has met the deductible. Provider numbers are available on the Medicaid Management Information System (MMIS) PM screen.
- 9. **Recipient's Share** - Enter the amount the applicant is responsible to pay on this bill.
- 10. **Amendment for Previous Form** - Check "Yes" if this is an amendment to a previous form. Check "No" if this is not an amendment to a previous form.
- 11. **Previous Form Date** - If you checked "Yes" an amendment to a previous form, enter the date of the previous form submitted.
- 12. **Comments** - Enter any comments.

### SECTION IV - SIGNATURE

- 13. **Signature** - The agency designee must sign this form. Medicaid will not process forms without a signature.

### DISTRIBUTION

White copy – Medicaid, Yellow copy – Provider whose bill met the deductible, Pink copy – Applicant's case file. Must be retained for three years.

## PROVIDER INSTRUCTIONS

You may be able to receive partial reimbursement from the Medicaid program for the charge(s) associated with the services listed on the reverse side of this form. However, a portion of the charge has been used to meet a Medicaid deductible for the person named on the reverse side. That person is liable for the Medicaid deductible and the Medicaid program will not reimburse you for that portion of the charge. Following is a description of the fields listed on the reverse side of this form.

### Field

1. Name of the agency certifying the individual for Medicaid.
2. Three digit identification number of the agency certifying the individual for Medicaid.
3. Identification number of the Income Maintenance worker who completed the Medicaid eligibility determination for the individual.
4. The applicant's name.
5. The Medicaid identification number of the person who received the service. This number should be used in claiming reimbursement from the Medicaid program.
6. Applicant's street address, city, state, and zip code.
7. The date of service which was the date that the deductible was met. This is the same as the date of service on the bill used to meet the deductible.
8. Your Medicaid provider number. If this number is incorrect, contact the certifying agency and worker listed in fields 1 and 3.
9. The exact amount for which the individual is liable.
10. Indicates if this is an amended form.
11. If this is an amended form, the date of the previous form is indicated.
12. Agency comments.

Indicate your usual and customary charge for the service rendered on the appropriate claim form. The claim should be submitted through the regular channels for claiming reimbursement from the Medicaid program. The amount listed in field 9 will be deducted automatically from the Medicaid allowed amount for the service rendered. The balance will be considered for payment. (Reference All Provider Handbook, Recipient Rights and Responsibilities, Spenddown section).